

The Anesthetist in the Practice of Medicine

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EXCEPT FOR a relatively few patients who come directly to him because of persistent pain or need of pneumatologic therapy, an anesthetist's practice is limited to patients referred to him by other physicians, usually surgeons. An unusual feature is that the anesthetist not only evaluates the status of the patient and suggests therapy but also administers the therapy in association with the surgeon. This is in contrast to the usual order of consultation in which the consultant examines the referred patient, makes a diagnosis and suggests therapy which is then applied by the patient's physician.

In this day of great specialization, there is a strong tendency to shift patients from one specialist to another in attempts to arrive at diagnoses and therapeutic procedures. Although this approach most often does what it is intended to do, perhaps more often than is warranted it results in confusion, inaccurate diagnosis and scrambled therapy. There is considerable merit in the fundamental principle that one physician must be responsible for the patient's welfare. This physician may enlist the aid of others, but the ultimate decision that influences the patient must be his.

The decision of the patient's physician to accept or reject the suggestions of the consultant depends upon a number of factors. The patient's physician is in the most favorable position to determine the therapy because he is most familiar with the background of the patient and the disease; he knows the progress of the disorder, the reactions of the patient to the situation, and he knows that he will be responsible for the results of the therapy. The extent to which the patient's physician uses the advice and professional service of consultants depends in large measure upon the confidence he has in those consultants. His confidence is the natural product of favorable experience over an extended period.

The physician entering the specialty of anesthesia often overlooks this important aspect of the practice of medicine. He may not remember that he is in a consultant capacity and cannot make a diagnosis or administer to the patient independently unless given that privilege by the patient's physician. Usually, as in the case of other consultants, this privilege is not extended until the patient's physician has de-

• In this age of specialization it is often difficult for the patient to determine who "his doctor" is. In the circumstances of anesthesia and surgery, the professional services of both physicians, the anesthetist and the surgeon, are highly integrated and the lines of responsibility must be clearly established. In the particularly close associations between anesthetist, surgeon and patient there is an urgent need for the application of scientific method in order to facilitate communication, improve the approach to the solution of problems, and enhance the welfare of the patient.

veloped complete confidence in the consultant. This confidence is not established automatically; unqualified recognition does not come immediately upon completion of approved training or even upon certification by the American Board of Anesthesiology.

Confidence is developed during the close association of anesthetist and surgeon in circumstances of stress. It grows from consistent demonstration by the consultant that he is familiar with the patient's disorder, that he is well versed basically and clinically in the practice of anesthesia, that he is alert to changes in the patient and in the demands of the surgical procedure, that he is genuinely concerned with the patient's welfare and with the progress of his disorder.

Discussion with the surgeon of all problems relating to the consultant's interest in the patient, before, during and after operation, will help to establish confidence. Imparting of pertinent information throughout these periods is a part of such discussions. For example, if a significant change occurs in the patient's condition—say a decrease in blood pressure—this information should be imparted to the surgeon. It is quite as important that the surgeon not neglect informing the anesthetist of the progress of and any unusual developments in the operative procedure. Neither becomes subservient to the other by such reporting. This point is somewhat labored here because for some unaccountable reason the anesthesia screen seems to be a barrier to communication. The barrier thwarts the patient's interest.

By some evolutionary process, or perhaps by authoritarian pronouncement of unknown provenance, a sort of grade-labeling is applied to the practitioners of anesthesia: Nurses are "anesthetists" and

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physicians are "anesthesiologists." These labels are based on arbitrary rules that imply that an "anesthetist" is less qualified to practice safe, satisfactory and comfortable anesthesia than is an "anesthesiologist." Labels like these, which totally disregard any evidence that may be contrary to the established precepts, are a reflection of an attitude that justifies the bungling and lethal efforts of the self-styled physician "anesthesiologist" and attempts to impugn the competent, experienced and often scientifically minded nurse-technician.

What are the factors that induce the nurse and the physician to take up the practice of anesthesia? What are the academic and clinical standards for the technical administration of anesthesia? What are the academic and clinical standards for the practice of anesthesia, including evaluation of patients, adaptability to change and the conduct of research? More importantly, by what process and what methods are the preceding standards developed, and are these standards subjected to constant revision in the light of new observations?

It may be assumed by some observers (although to me it seems that there is no evidence to warrant the assumption) that the above questions are to be put, the observations made and the results evaluated by physicians in the practice of anesthesia. To me it seems proper that all who are concerned with the practice of anesthesia—nurses, hospital administrators, surgeons and others, as well as anesthetists—should ask the questions and make the observations. The cooperative, unbiased, unemotional—in short, the scientific—approach to the problem is essential to a solution. And the solution must be subject to alteration as the need is demonstrated.

The method of science consists of asking clear questions, making direct, unprejudiced and thorough observations, using those observations to answer as well as possible the questions asked, and revising or discarding any previously formed beliefs or assumptions that cannot stand in the light of the new observations.

It is well to emphasize that science as a method is not utilized to its fullest extent if the process ceases with a single application of the method. New questions must be asked and new observations made for scientific profit to the individual or to our culture.

One of the more fascinating aspects of the practice of anesthesia is the multiplicity of problems. It is difficult to ignore the succession of intriguing

opportunities for reflection, study and investigation. Nevertheless, these opportunities are too often abandoned by resorting "to the book," by retreating behind "accepted practice," or by militantly supporting "authority." By so doing, one consistently constricts his outlook and becomes gradually but surely a simple technician instead of a practitioner of medicine. Such an approach to practice is not excusable; even less forgivable is the failure to recognize the innumerable questions inviting inquiry.

Such attitudes will not lead to answers to the basic question of the mechanism of the production of the anesthetic state, to the solution of the mystery of the distribution of anesthetic agents, to the clarification of "fixing" of anesthetics introduced intrathecally, to the determination of the manner in which d-tubocurarine is so rapidly removed from the circulation, to a better understanding of the mechanisms involved in the production, perception and response to pain, to the prevention of nausea and emesis associated with the administration of narcotic drugs, or to the delineation of many other problems.

Not everyone has the time, the facilities, the financial support or the inclination to conduct full-scale clinical or laboratory investigation into the problems that come to his attention. However, everyone who accepts and enters medicine as a profession is obligated to maintain an agnostic attitude, to raise questions and to search for answers. Research is defined as a diligent and systematic inquiry into a subject in order to discover facts or principles. It is a process in which everyone in the practice of medicine can and should participate. It is a process intrinsic in those who possess and develop an open mind. It is a continual process that is not restricted to the laboratory; it should be used in the clinic, in the library, in the easy chair at home, in the dressing room at the hospital, in the occasional free hour in the office.

The practitioner of medicine who accepts the invitations for inquiries that are presented in the specialty of anesthesia avails himself of the opportunity to exploit his background of basic science in the solution of clinical problems. What other specialty in medicine offers to the physician more dynamic, more acute and more profound changes, the investigation of which promotes the welfare of the patient, enhances medical knowledge and encourages a happy and productive professional life?

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